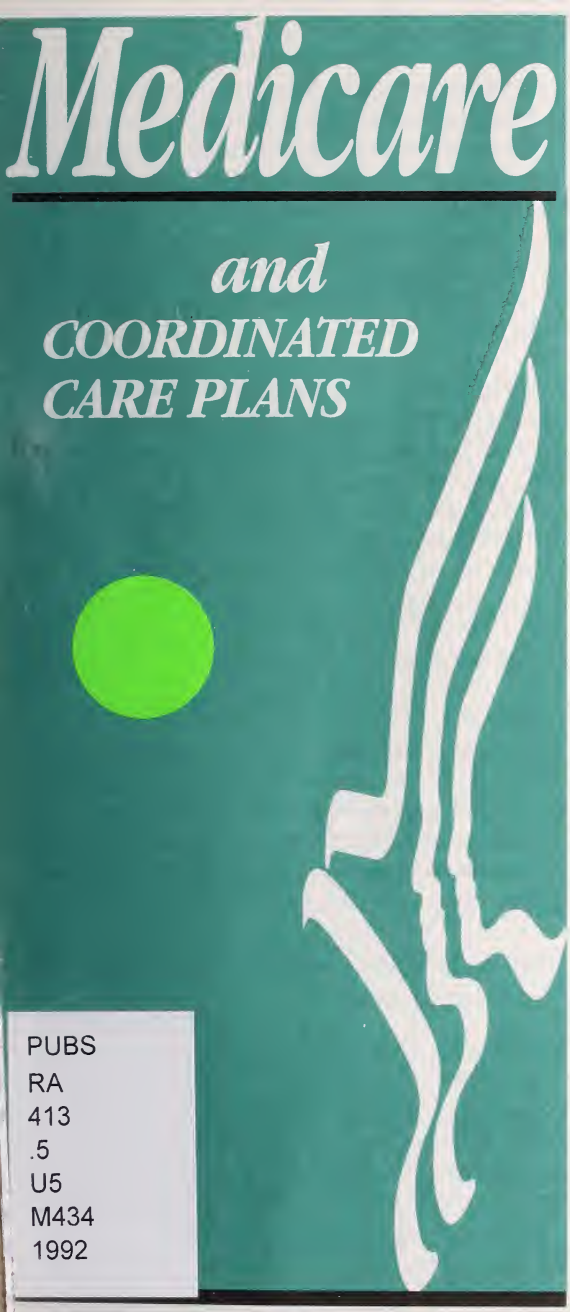
Medicare

and COORDINATED CARE PLANS



U.S. Department of Health and Human Services
Health Care Financing Administration

It's your choice!

As a Medicare beneficiary, you can choose how you will receive hospital, doctor and other health care services covered by Medicare. You can receive them either through the traditional fee-for-service (pay-as-you-go) delivery system or through coordinated care plans [health maintenance organizations (HMOs) and competitive medical plans (CMPs)] which have contracts with Medicare.

Whether you choose fee-for-service or coordinated care, you get all of Medicare's hospital and medical benefits. The differences in the two systems include how the benefits are delivered, how and when payment is made and how much you might have to pay out of your pocket. This leaflet, while making brief mention of the fee-for-service system, is intended to provide a general explanation of the coordinated care option under Medicare. If you want more detailed information about the fee-for-service system, refer to *The Medicare Handbook*. Copies are available from any Social Security Administration office.

How do the fee-for-service and coordinated care systems work?

Fee-for-Service Care

Under the fee-for-service payment system, you can choose any licensed physician and use the services of any hospital, health care provider or facility certified by Medicare. Generally, a fee is paid each time a service is used. While Medicare, within certain limits, will pay a large portion of your hospital, physician and other health care expenses, you are liable for Medicare's deductibles and coinsurance amounts. You must also

pay all permissible charges in excess of Medicare's approved amounts, and charges for services not covered by Medicare. Some of these potential out-of-pocket costs can be avoided or reduced through the purchase of private supplemental insurance, called "Medigap" insurance, which is specifically designed to close some of the payment gaps in your Medicare coverage.

Coordinated Care Plans

In a coordinated care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) generally offers comprehensive, coordinated medical services to plan members on a prepaid basis. Services usually must be obtained from the professionals and facilities that are part of the plan. If you enroll in a coordinated care plan that has a contract with Medicare, a monthly payment is made to the plan by Medicare. In addition, most plans charge enrollees nominal copayments and a monthly premium instead of the deductible and coinsurance amounts that you would pay under the fee-for-service system. In return, the plan provides you with all Medicare hospital and medical benefits available in the plan's area if you are enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B).

Some plans also provide benefits beyond what Medicare pays for, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses. There usually are no additional charges—no matter how many times you visit the doctor, are hospitalized, or use other covered services.

Why join a coordinated care plan?

People join coordinated care plans for several reasons. The most frequently mentioned include:

- It's generally easier to get care through one

source (for example, doctors' services, hospital care, laboratory tests, X-rays, etc.)

- Quality of care may be enhanced because of the coordination of services.

- You can more easily budget health care costs because you know the amount of any premiums in advance, and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.

- You generally pay only a nominal copayment when you use a service. Some plans do not charge copayments for certain specified services.

- In many cases, benefits beyond those covered by Medicare are available at either no additional charge or a nominal charge. Extra benefits may include prescription drugs, physicals, immunizations, dental care, eyeglasses and hearing aids.

- You will **not** need Medigap insurance to supplement your Medicare coverage because the plan provides you with all or most of the same benefits at no additional cost.

Are there any other factors to consider in deciding whether to enroll in a coordinated care plan?

Consider whether the plan's providers are in a convenient location and whether adequate transportation is available to get you to them. Most plans have a "**lock-in**" provision. This means that usually you must receive all of your medical care and services from the plan or from facilities and specialists affiliated with the plan. In most cases, if you receive unauthorized health care services from any other sources, neither the plan nor Medicare will pay for those services.

If you are considering enrolling in a coordinated care plan, but are reluctant to do so because you have been going to your present doctor for a long time, ask whether your doctor is a participating physician in a plan. If your doctor is, then you may be able to enroll in the plan and continue to use his or her services. If your doctor is not affiliated with a plan, you may want to discuss with a plan representative how you will obtain health care services if you join.

Before enrolling, get information about the doctors available to serve you, the hospitals the plan uses, all auxiliary services and, if you travel frequently, your out-of-area coverage. Also, ask about services for any medical condition for which you are being treated, keeping in mind that you cannot be denied membership because of a pre-existing condition.

Medigap insurance is another issue that you should consider if you are thinking about enrolling in a plan, or if you are already in a plan and are thinking about disenrolling. The plan is not permitted to enroll you if you have a Medigap policy, and as a plan member, you should not need Medigap insurance. If you enroll in a plan and later later decide to disenroll and return to the fee-for-service system, be aware that you may not be able to buy a Medigap policy on favorable terms. This is especially true if you have a pre-existing health condition.

Can I enroll in a coordinated care plan?

Most Medicare beneficiaries are eligible for enrollment in a coordinated care plan. Many HMOs and CMPs are under contract with the Federal government to serve Medicare beneficiaries, and there are such plans in most parts of the country. In addition to being called coordinated care plans, they also are know as prepaid or managed care plans. HMOs and CMPs with

Medicare contracts cannot screen their applicants to find whether they are healthy or delay coverage for a pre-existing condition. The only enrollment requirements are:

- You must at least be enrolled in Medicare Supplementary Medical Insurance (Part B) and continue to pay the Part B monthly premium.

- If you also have Medicare Hospital Insurance (Part A), and most beneficiaries do, the plan will provide both Medicare hospital and medical benefits. The Part B monthly premium ($31.80 in 1992) is usually deducted from your Social Security or Railroad Retirement check. It is not the same as the monthly premium charged by most plans.

- You must live within the area in which the plan has agreed to provide services;

- You cannot have elected care from a Medicare-certified hospice*; and

- You cannot be medically determined to have end-stage renal disease*.

*If you choose hospice care after joining a coordinated care plan, you will receive hospice services from a Medicare-approved hospice, but you may, if you wish, continue your enrollment in the plan. If you do, the plan is required to continue to provide or arrange for all care unrelated to the terminal condition. Also, if after joining a plan you are medically determined to have end-stage renal disease, the plan is required to provide or arrange for your care.

How can I join a plan?

To join a coordinated care plan, get in touch with plans in your area to find out which plans have Medicare contracts. The names of those plans are available from your local Social Security Administration office. All contracting HMOs and CMPs have an advertised open enrollment period of at least 30 days once a year.

Before you join an HMO or CMP, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. And if you live in an area served by more than one coordinated care plan, compare benefits, costs and other features to determine which plan best suits your needs at a price you can afford.

If I enroll, where do I go for care?

Depending on the type of plan, the services are provided either at one or more centrally located health facilities or in the private practice offices of the professionals affiliated with the plan. If it is a group practice or "staff model" plan, the services generally are provided at central locations operated by the plan. If it is an individual practice plan, the services are provided in private practice offices of the physicians and other health care professionals who are part of the plan.

Be aware that each plan is different. They use different doctors and hospitals, charge different premiums, and have different administrative policies. You will want to examine the plans you are thinking of joining and consider how they compare with each other.

Health Care Prepayment Plans

In addition to its contracts with HMOs and CMPs, Medicare has agreements with health care prepayment plans (HCPPs). They are unlike

HMOs and CMPs that have contacts with Medicare in that they only partially cover Medicare benefits. Some HCPPs cover all Part B benefits and others cover only some of them. Although HCPPs do not cover Medicare Part A services, some arrange such services and may file Part A claims on your behalf. You should be aware that a plan with an HCPP agreement may also have enrollment requirements and other rules that are different than those of an HMO or CMP.

Who pays if I have an accident at home and get emergency care from a hospital or doctor not with the plan?

In an emergency, you can go to a non-plan doctor or hospital for care. The doctor or hospital should be advised that you are a member of a plan, and you or a member of your family should notify the plan as soon as possible that care was received from a non-plan provider. The plan will pay for care received in the service area from non-plan providers only if services are needed immediately because of an injury or sudden illness, and if delay in reaching a plan provider would result in the risk of permanent damage to your health.

What if I get sick away from home?

When you're temporarily outside the plan's service area, the plan pays for emergency or urgently needed medical care, but not for routine care or care that could have been anticipated. Under certain circumstances, however, a plan may make arrangements for members to receive services when they are absent from the service area. A plan might also offer coverage for out-of-area services as an additional benefit.

Will I always have the same doctor?

When you enroll, most coordinated care plans allow you to select a primary care doctor from those affiliated with the plan. If you do not make a selection, a primary care doctor will be assigned to you. Primary care doctors are responsible for managing their patients' medical care and admitting them to a hospital. All health services are obtained through your designated primary care doctor. If for any reason you want to change your primary care doctor, the plan generally will let you do so as long as you pick another one of the plan's primary care doctors.

What about specialists and hospital care?

Coordinated care plans use a full assortment of specialists. Usually, you must be referred to a specialist by your primary care physician if the plan is to cover the specialist's services. And just as a plan arranges in advance with specific doctors to care for members, it generally has contracts with specific hospitals, skilled nursing facilities, home health care agencies and other health care providers to serve its members. Some of the larger plans have their own hospitals and other health care facilities. In most cases plan members must use those designated providers or the plan will not pay for the care. Moreover, Medicare generally will not pay for care not authorized by your coordinated care plan.

What if the coordinated care plan refuses to pay for medically necessary care?

If a plan refuses to pay for or provide medically necessary covered services, and you believe it should pay for or provide the services, you have guaranteed appeal rights under the Medicare law. These rights are explained in the health plan's description of its benefits and coverage.

What if I am not satisfied with the care I receive?

If you are dissatisfied with the quality of care provided, you can:

- follow your plan's grievance procedure,
- write, or in some cases, call your Peer Review Organization (PRO)*, or
- disenroll at any time, effective the following month.

How do I get out of a plan?

If you enroll in a plan and later decide to return to fee-for-service Medicare coverage, you may disenroll at any time, effective the first day of the following month. To disenroll, all you need to do is state in writing that you want to withdraw from the plan and return to traditional Medicare coverage. Give the written statement either to the plan's administrative office or to your local Social Security Administration or Railroad Retirement Board office. Your coverage under the fee-for-service system will begin the first day of the following month. If you want to change from one plan to another, you may do so by simply enrolling in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

*PROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients. They are listed in *The Medicare Handbook*.

Medicare SELECT available in certain States

A new health insurance product that incorporates some of the features of a coordinated care plan may be available in designated States to supplement your Medicare benefits. The States where these policies are currently authorized to be sold are Alabama, Arizona, California, Florida, Indiana, Kentucky, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington and Wisconsin. Medicare SELECT is private Medigap insurance that will be offered in the designated States by insurance companies and HMOs in essentially the same way that traditional Medigap policies are made available. And just like Medigap insurance, Medicare SELECT policies will be required to meet certain Federal standards and will be regulated by the States in which they are approved.

The principal difference between Medicare SELECT and standard Medigap insurance is benefits under a Medicare SELECT policy may be restricted to items and services furnished by particular providers, or the policy may pay reduced benefits for services that are not obtained from those particular providers. These health care professionals, called "preferred providers," will be selected by the insurers. Each organization that offers a Medicare SELECT policy will have its own network of preferred providers.

When a Medicare SELECT policyholder receives covered services from a preferred provider, Medicare will pay its share of the approved charges, and the Medicare SELECT insurer will pay some or all of the balance of the bill, depending on the limits of the policy.

Medicare SELECT policies must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network. In general, Medicare SELECT policies will deny payment or pay less than the full benefit if the policyholder goes outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges in such situations. This arrangement should result in lower premium rates for Medicare SELECT policies than for other Medigap insurance.

During the three-year period in which sale of these policies is currently authorized under Federal law, Medicare SELECT will be evaluated to determine if it should be made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage in the event the Medicare SELECT program is not continued. This means that if you buy a Medicare SELECT policy and the program is not extended, you will have the option to purchase any traditional Medigap policy that the company offers and which includes comparable or lesser benefits than those provided by the Medicare SELECT policy.

The insurance departments of the 15 designated States can tell you which insurers have been authorized to write Medicare SELECT policies in their respective States.

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